STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814

September 21, 1987

ALL COUNTY LETTER NO. 87-128

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: REDUCED INCOME SUPPLEMENTAL PAYMENTS
(FORMERLY: HARDSHIP SUPPLEMENTAL PAYMENTS)

REFERENCE: ACL 86-110, ACL 86-122, ACL 87-30
MPP SECTIONS 44-400 - 44-403

On January 1, 1987, emergency regulations (ORD No. 0986-45) implementing hardship supplemental payments (HSP) for AFDC, RCA, and RDP recipients went into effect. Implementing instructions were issued in All County Letter (ACL) 86-110. Fiscal claiming instructions were issued in ACL 86-122. ACL 87-30 provided answers to questions concerning HSPs.

This letter provides information about recent changes affecting HSPs and highlights the most notable change. In addition, the letter transmits reproducible copies of revised notices of action (NOA), replacement pages for the NOA Handbook, the recipient informing notice, and the revised Supplemental Payment Request Form (CA 40) which are required by the changes.

If you have questions concerning information in this letter about supplemental payments, please contact Judy Moore at (916) 324-2017 or ATSS 454-2017.

ROBERT A. HOREL
Deputy Director

Attachments

cc: CWDA

ATTACHMENT I

SUMMARY OF REGULATION CHANGES

In the filing of the final (compliance) package, changes were made to the supplemental payment regulations effective May 13, 1987. A letter dated May 6, 1987 from Joanne Ichimura-Hoffmann, Deputy Director of the Management Systems and Evaluation Division, transmitted the proposed revisions to the regulations to all county welfare directors. The most notable change affects the name, hardship supplemental payment, which is now designated as the "reduced income supplemental payment" (RISP).

CA 40 AND NOAs

Changes were made to the Supplemental Payment Request Form (CA 40) based on input from the CWDA Forms Subcommittee. A reproducible copy of the revised form is included in Attachment II to this letter. In addition to the name change noted above, the computation on the CA 40 has been revised by converting the former two-step computation into a single computation. The revised CA 40 also has more space for county information and is formatted to allow the use of window envelopes. Attachment III contains examples which illustrate how the revised computation is applied.

The recipient informing notice (M44-400A), and NOA messages M44-401A, M44-401B, M44-401D, and M44-403A, originally transmitted by ACL 86-110, have been revised to incorporate the name change, computational changes, and minor changes in the message language. (NOA message M44-401C has been eliminated as a result of the computational change making the income "test" illustrated on M44-401C obsolete.) Attachment II contains reproducible copies of each NOA and the informing notice, in addition to the NOA Handbook pages.

Counties who order forms from the DSS Warehouse should continue to use the 10/86 version of the CA 40 until the 7/87 version is available from the warehouse. Counties who print their own forms may deplete existing stock of CA 40s and HSP NOAs prior to converting to the revised materials. However, implementation of the revised CA 40s and the new NOAs should coincide to avoid client confusion.

Translations of the CA 40 and NOAs in the five standard languages will follow under separate cover. Additional copies of the NOA Handbook pages will be included in the next updates to the Handbook.

ATTACHMENT II

- CA 40
- NOTICES OF ACTION
- NOA HANDBOOK PAGES

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

AFDC — REDUCED INCOME SUPPLEMENTAL PAYMENT REQUEST

YOU MAY GET EXTRA MONEY IF THE COUNTY IS COUNTING INCOME AGAINST YOUR CASH AID AND THAT INCOME HAS **DROPPED** OR **STOPPED**.

- You must use **this form** to ask for the extra money.
- You must apply in the month that you need the extra money, not before or after.
- You must **complete and return** a separate form during **each month** that the county is counting income that has dropped or stopped against your cash aid.
- You can get only **one** extra payment per month.
- If you get extra money, your food stamp benefits may be affected.

The county must determine your eligibility for extra money within 7 working days after the date this completed form is received.

If you don't need the form now, keep it for later.

Questions? Ask your worker.

COUNTY USE ONLY

DATE POSTMARKED

CASE NAME AND NUMBER

1. We want extra money for _____ (MONTH). In this month we expect the following income and expenses:

INCOME

Gross Earnings $ _____

Other Income $ _____

List Source: _____

EXPENSES

Dependent Care Cost $ _____

Child/Spousal Support Cost $ _____

2. Explain about the income that dropped or stopped.

A. What income changed:

B. When it changed:

C. Why it changed:

3. Attach proof of the change in income (Job Termination Notice, SSA/DIB/UIB Notices, Statements, etc.). If you have no proof, list the employer or agency that can be contacted:

EMPLOYER/AGENCY	PHONE
ADDRESS	

4. Complete the following:

CASE NAME	YOUR SOCIAL SECURITY NUMBER
CASE NUMBER	WORKER NAME/NUMBER

Supp. Month	
Est. Earned Income	$
W/E Disregard	—
Dep. Care Disregard	—
Net Earnings	= $
Total Aid Before O/P Adj.	+
Special Needs	—
Disregards Not Allowed	+
Other Countable Income	+
Support Disregards	+
Net Available Income	$
80% MAP	$
Net Available Income	—
Supplemental Payment	$

COMMENTS:

☐ APPROVED ☐ DENIED

EW SIGNATURE DATE

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification including contacting the above named person, employer or agency.
- **I further declare under penalty of perjury under the laws of the State of California that the statements I have given on this form are true and correct to the best of my knowledge.**
- I authorize the county to obtain any verification of income and circumstances necessary to process this request. This authorization is valid for 30 days from the date signed.

SIGNATURE	DATE SIGNED
SIGNATURE OF SPOUSE OR OTHER ADULT RECIPIENT	DATE SIGNED
ADDRESS CITY	PHONE

On this form, disclosure of your Social Security Number (SSN) is voluntary. The SSN will be used to identify you and your records. If we cannot identify you, you may not get any extra money.

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

{ADDRESSEE}

Questions? Ask your Worker.

If Your Income Drops . . .

After your first two months of cash aid, we figure your aid amount by counting your income from two months ago. If your income drops too much, it may cause a hardship. Then we may give you what's called a "Reduced Income Supplemental Payment".

You may be able to get a supplemental payment if:

1) your countable income this month is going to be less than it was two months ago and

2) your income this month plus your cash aid amount is less than 80% of the basic cash aid your family would get if you had no income;

or

3) your case has been suspended for the month.

You must apply for a supplemental payment in each month that you think you should get it.

Use the AFDC Reduced Income Supplemental Payment Request Form CA-40 to apply for the supplemental payment.

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

The County has approved your application for a reduced income supplemental payment dated _____ .

The amount of your supplement is figured on this notice.

You must apply for a supplemental payment in each month you think you should get it.

Supplemental Payment Amount for _____ (MONTH)

Estimated Earned Income	$ _____
Work Expense Disregard	– _____
Dependent Care Disregard	– _____
Net Earnings	= _____
Total Aid This Month before Overpayment Adjustments	+ _____
Special Needs	– _____
Disregards Not Allowed	+ _____
Other Countable Income	+ _____
Support Disregards	+ _____
Net Available Income	= _____
80% of Basic Aid	$ _____
Net Available Income	– _____
Supplemental Payment	$ _____

☐ You will get another notice about your Medi-Cal.

Rules: These rules apply. You may review them at your welfare office:

NOTICE OF ACTIO!

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

The County has denied your application for a reduced income supplemental payment dated _____.

Here's why:

Your "net available income" this month is more than 80% of the basic aid you would get if you had no income.

Your net available income and 80% of your basic aid amount are figured on this notice.

Estimated Earned Income	$ _____
Work Expense Disregard	– _____
Dependent Care Disregard	– _____
Net Earnings	= _____
Total Aid this Month before Overpayment Adjustments	+ _____
Special Needs	- _____
Disregards Not Allowed	+ _____
Other Countable Income	+ _____
Support Disregards	+ _____
Net Available Income	$ _____
80% of Basic Aid	$ _____

☐ You will get another notice about your Medi-Cal.

Rules: These rules apply. You may review them at your welfare office:

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

The County has denied your application for a reduced income supplemental payment dated _____ .

Here's why:

- ☐ Your family cannot get regular cash aid this month.
- ☐ You already got a supplemental payment this month.
- ☐ You did not have income which dropped or stopped.
- ☐ You applied for a supplemental payment for a past month. You must apply for it in the same month you need it.
- ☐ You applied last month for a supplemental payment this month. You must apply for it in the same month you need it. We may give you a supplemental payment if you apply again this month and give us the facts we need.

☐ You will get another notice about your Medi-Cal.

Rules: These rules apply. You may review them at your welfare office:

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone : _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

The County has denied your application for a reduced income supplemental payment dated _____ . Here's why:

You did not give us all the facts we needed.

We need to have proof of your change in income (Job Termination Notice, SSA/ DIB/UIB Notices, Statements, etc.).

If you don't have the proof, we need the name of the employer or agency that we can contact.

We may give you a supplemental payment if you apply again this month and give us the facts we need.

☐ You will get another notice about your Medi-Cal.

Rules: These rules apply. You may review them at your welfare office:

State of California
Department of Social Services

Auto ID No. :
Flow Chart No. :
Source : Hardship Suppl.
Regulation Cite: 44-400

Manual Msg. No.: M44-400A
Action : Inform
Reason: Hardship Supplement
Title: Hardship Supplement
Form No. :
Effective Date : 01/01/87
Revision Date : 08/31/87

MESSAGE:

If Your Income Drops...

After your first two months of cash aid, we figure your aid amount by counting your income from two months ago. If your income drops too much, it may cause a hardship. We may give you what's called a "Reduced Income Supplemental Payment".

You may be able to get a supplemental payment if:

1) your countable income this month is going to be less than it was two months ago and

2) your income this month plus your cash aid amount is less than 80% of the basic cash aid your family would get if you had no income;

or

3) your case has been suspended for the month.

You must apply for a supplemental payment in each month that you think you should get it.

Use the AFDC Reduced Income Supplemental Payment Request Form CA-40 to apply for the supplemental payment.

INSTRUCTIONS: For counties which do not use the CA 2 for redetermination, use to notify recipients at redetermination of the availability of hardship supplements.

This message replaces M44-400A (5/4/87).

State of California
Department of Social Services

Auto ID No. :
Flow Chart No. :
Source : RISP
Regulation Cite: 44-401.2

Manual Msg. No.: M44-401A
Action : Approve
Reason: Hardship Supplement
Title: Supplemental Payment
Form No. : NA290
Effective Date : 01/01/87
Revision Date : 07/19/87

MESSAGE: The County has approved your application for a reduced income supplemental payment dated _____.

The amount of your supplement is figured on this notice.

You must apply for a supplemental payment in each month you think you should get it.

Supplemental Payment Amount for _____

Estimated Earned Income	$_____
Work Expenses Disregard	-_____
Dependent Care Disregard	-_____
Net Earnings	=_____
Total Cash Aid this month before Overpayment Adjustments	+_____
Special Needs	-_____
Disregards not Allowed	+_____
Other Countable Income	+_____
Support Disregards	+_____
Net Available Income	$_____
80% of Basic Aid	$_____
Net Available Income	-_____
Supplemental Payment	$_____

INSTRUCTIONS: Use to notify an AU that its request for a hardship supplemental payment has been approved.

Fill in the postmark date or date of county receipt of the request for RISP (MPP Section 44-401).

Complete the computation.

This message replaces M44-401A (11/6/86).

State of California
Department of Social Services

Auto ID No. :
Flow Chart No. :
Source : RISP
Regulation Cite: 44-401.22

Manual Msg. No.: M44-401B
Action : Deny
Reason: Hardship Supplement
Title: Income Over 80% of MAP
Form No. : NA290
Effective Date : 01/01/87
Revision Date : 07/19/87

MESSAGE: The County has denied your application for a reduced income supplemental payment dated _____.

Here's why:

Your "net available income" this month is more than 80% of the basic aid you would get if you had no income.

Your net available income and 80% of your basic aid amount are figured on this notice.

Estimated Earned Income	$_____
Work Expense Disregard	-_____
Dependent Care Disregard	-_____
Net Earnings	=_____
Total Cash Aid this Month before Overpayment Adjustments	+_____
Special Needs	-_____
Disregards Not Allowed	+_____
Other Countable Income	+_____
Support Disregards	+_____
Net Available Income	$_____
80% of Aid	$_____

INSTRUCTIONS: Use to deny a request when the net available income exceeds 80% of MAP.

Fill in the postmark date or the date of county receipt of the request for RISP (MPP Section 44-401.232).

Complete the computation.

This message replaces M44-401B (11/06/86).

State of California
Department of Social Services

Auto ID No. :
Flow Chart No. :
Source : RISP
Regulation Cite: 44-401.2, 44-401.4

Manual Msg. No.: M44-401D
Action : Deny
Reason: Hardship Supplement
Title: Various Reasons
Form No. : NA290
Effective Date : 01/01/87
Revision Date : 07/19/87

MESSAGE: The County has denied your application for a reduced income supplemental payment dated _____.

Here's why:

[ ] Your family cannot get regular cash aid this month.

[ ] You already got a supplemental payment this month.

[ ] You did not have any income which dropped or stopped.

[ ] You applied for a supplemental payment for a past month. You must apply for it in the same month you need it.

[ ] You applied last month for a supplemental payment this month. You must apply for it in the same month you need it. We may give you a supplemental payment if you apply again this month and give us the facts we need.

INSTRUCTIONS: Use to deny a request when the AU did not apply for the hardship supplemental payment in the same month they could get one, when the AU was not eligible for AFDC, when the AU already received a hardship supplemental payment in the same month, or when the AU does not have any income which dropped or stopped.

Fill in the postmark date or the date of county receipt of the request for RISP (MPP 44-401.232).

Check the appropriate box. Check the 4th box if the client applied for a RISP in a previous month. Check the 5th box if the client applied in a previous month for a RISP this month.

This message replaces M44-401D (11/6/87)

State of California
Department of Social Services

Auto ID No. :
Flow Chart No. :
Source : RISP
Regulation Cite: 44-403.5

Manual Msg. No.: M44-403A
Action : Deny
Reason: Hardship Supplement
Title: Lack of Information
Form No. : NA290
Effective Date : 01/01/87
Revision Date : 07/19/87

MESSAGE: The County has denied your application for a reduced income supplemental payment dated _____.

Here's why:

You did not give us all the facts we needed.

We need to have proof of your change in income (Job Termination Notice, SSA/DIB/UIB Notices, Statements, etc.).

If you don't have the proof, we need the name of the employer or agency that we can contact.

We may give you a supplemental payment if you apply again this month and give us the facts we need.

INSTRUCTIONS: Use to deny a request when the County is unable to obtain adequate information to determine eligibility for a supplemental payment.

Fill in the postmark date or date of county receipt of the the request for RISP (MPP 44-401.232).

This message replaces M44-403A (11/6/86).

ATTACHMENT III

- EXAMPLES A - G

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

AFDC — REDUCED INCOME . PPLEMENTAL PAYMENT REL EST

THAT INCOME HAS DROPPED OR STOPPED.

e that has dropped or stopped against your cash aid.

pleted form is received.

EXAMPLE A

AU = 4
MAP = $734

MOM'S NET NON EXEMPT INCOME (NNI) IN NOVEMBER WAS $300. HER JANUARY GRANT IS $434.

MOM's JOB ENDED IN DECEMBER.
MOM APPLIED FOR A RISP IN JANUARY.

COUNTY USE ONLY

DATE POSTMARKED:

CASE NAME AND NUMBER:

Supp. Month		JAN.
Est. Earned Income	$	0
W/E Disregard	—	
Dep. Care Disregard	—	
Net Earnings	= $	
Total Aid Before O/P Adj.	+	434
Special Needs	—	
Disregards Not Allowed	+	
Other Countable Income	+	
Support Disregards	+	
Net Available Income	$	434
80% MAP	$	587
Net Available Income	—	434
Supplemental Payment	$	153

COMMENTS:

☑ APPROVED ☐ DENIED

EW SIGNATURE DATE

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification including contacting the above named person, employer or agency.
- I further declare under penalty of perjury under the laws of the State of California that the statements I have given on this form are true and correct to the best of my knowledge.
- I authorize the county to obtain any verification of income and circumstances necessary to process this request. This authorization is valid for 30 days from the date signed.

SIGNATURE — DATE SIGNED

SIGNATURE OF SPOUSE OR OTHER ADULT RECIPIENT — DATE SIGNED

ADDRESS — CITY — PHONE

On this form, disclosure of your Social Security Number (SSN) is voluntary. The SSN will be used to identify you and your records. If we cannot identify you you may not get any extra money.

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

AFDC — REDUCED INCOME SUPPLEMENTAL PAYMENT REQUEST

D THAT INCOME HAS **DROPPED** OR **STOPPED.**

e that has dropped or stopped against your cash aid.

pleted form is received.

EXAMPLE B

AU = 2
MAP = $498

MOM'S HOURS WERE REDUCED IN JANUARY REDUCING HER EARNED INCOME TO $200.

IN NOVEMBER, MOM'S NET COUNTABLE INCOME WAS $250. MOM'S JANUARY GRANT IS $248. MOM RECEIVES CHILD SUPPORT AND THE FOLLOWING DISREGARDS:

$75 WORK EXPENSE
$60 DEPENDENT CARE
$30 DISREGARD

MOM APPLIED FOR A RISP IN JANUARY.

COUNTY USE ONLY

DATE POSTMARKED:

CASE NAME AND NUMBER:

Supp. Month		JAN.
Est. Earned Income	$	200
W/E Disregard	—	75
Dep. Care Disregard	—	60
Net Earnings	= $	65
Total Aid Before O/P Adj.	+	248
Special Needs	—	
Disregards Not Allowed	+	
Other Countable Income	+	
Support Disregards	+	50
Net Available Income	$	363
80% MAP	$	398
Net Available Income	—	363
Supplemental Payment	$	35

COMMENTS:

☑ APPROVED ☐ DENIED

EW SIGNATURE DATE

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification including contacting the above named person, employer or agency.
- **I further declare under penalty of perjury under the laws of the State of California that the statements I have given on this form are true and correct to the best of my knowledge.**
- I authorize the county to obtain any verification of income and circumstances necessary to process this request. This authorization is valid for 30 days from the date signed.

SIGNATURE — DATE SIGNED

SIGNATURE OF SPOUSE OR OTHER ADULT RECIPIENT — DATE SIGNED

ADDRESS — CITY — PHONE

On this form, disclosure of your Social Security Number (SSN) is voluntary. The SSN will be used to identify you and your records. If we cannot identify you, you may not get any extra money.

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

AFDC — REDUCED INCOME JPPLEMENTAL PAYMENT RE JEST

) THAT INCOME HAS **DROPPED** OR **STOPPED.**

e that has dropped or stopped against your cash aid.

pleted form is received.

EXAMPLE C

AU = 1 (PREGNANT WOMAN)

MAP + PSN = $373

CLIENT'S HOURS WERE REDUCED IN JANUARY.

SHE RECEIVES THE $75 WORK EXPENSE DISREGARD AND THE $30 DISREGARD.

SHE ALSO RECEIVES A PREGNANCY SPECIAL NEED.

HER JANUARY GRANT IS $173.

SHE APPLIED FOR A RISP IN JANUARY.

COUNTY USE ONLY

DATE POSTMARKED:

CASE NAME AND NUMBER:

Supp. Month		JAN.
Est. Earned Income	$	230
W/E Disregard	—	75
Dep. Care Disregard	—	
Net Earnings	= $	155
Total Aid Before O/P Adj.	+	173
Special Needs	—	70
Disregards Not Allowed	+	
Other Countable Income	+	
Support Disregards	+	
Net Available Income	$	258
80% MAP	$	242
Net Available Income	—	258
Supplemental Payment	$	Ø

COMMENTS:

☐ APPROVED ☑ DENIED

EW SIGNATURE DATE

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification including contacting the above named person, employer or agency.
- **I further declare under penalty of perjury under the laws of the State of California that the statements I have given on this form are true and correct to the best of my knowledge.**
- I authorize the county to obtain any verification of income and circumstances necessary to process this request. This authorization is valid for 30 days from the date signed.

SIGNATURE — DATE SIGNED

SIGNATURE OF SPOUSE OR OTHER ADULT RECIPIENT — DATE SIGNED

ADDRESS — CITY — PHONE

On this form, disclosure of your Social Security Number (SSN) is voluntary. The SSN will be used to identify you and your records. If we cannot identify you, you may not get any extra money.

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

AFDC — REDUCED INCOME SUPPLEMENTAL PAYMENT REQUEST

D THAT INCOME HAS DROPPED OR STOPPED.

e that has dropped or stopped against your cash aid.

pleted form is received.

EXAMPLE D

AU = 3 (Mom and 2 Children)
MAP = $617

MOM'S EARNED INCOME IN NOVEMBER AND JANUARY WAS $300. SHE RECEIVED THE $75 WORK EXPENSE DISREGARD. MOM'S JANUARY GRANT IS $392.

IN DECEMBER, GRANDMOTHER WHO HAD BEEN PROVIDING MOM WITH FREE CHILD CARE WENT INTO THE HOSPITAL. THIS EXPENSE WAS NOT ANTICIPATED. MOM'S ELIGIBILITY FOR THE DEPENDENT CARE DISREGARD IN JANUARY RESULTS IN A DECREASE IN MOM'S NNI. MOM IS ELIGIBLE FOR A $200 DEPENDENT CARE DISREGARD IN JANUARY.
MOM HAS APPLIED FOR A RISP IN JANUARY.

COUNTY USE ONLY

DATE POSTMARKED

CASE NAME AND NUMBER

Supp. Month		JAN.
Est. Earned Income	$	300
W/E Disregard	—	75
Dep. Care Disregard	—	200
Net Earnings	= $	25
Total Aid Before O/P Adj.	+	392
Special Needs	—	
Disregards Not Allowed	+	
Other Countable Income	+	
Support Disregards	+	
Net Available Income	$	417
80% MAP	$	494
Net Available Income	—	417
Supplemental Payment	$	77

COMMENTS:

☑ APPROVED ☐ DENIED

EW SIGNATURE DATE

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification including contacting the above named person, employer or agency.
- I further declare under penalty of perjury under the laws of the State of California that the statements I have given on this form are true and correct to the best of my knowledge.
- I authorize the county to obtain any verification of income and circumstances necessary to process this request. This authorization is valid for 30 days from the date signed.

SIGNATURE — DATE SIGNED

SIGNATURE OF SPOUSE OR OTHER ADULT RECIPIENT — DATE SIGNED

ADDRESS — CITY — PHONE

On this form, disclosure of your Social Security Number (SSN) is voluntary. The SSN will be used to identify you and your records. If we cannot identify you, you may not get any extra money.

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

AFDC — REDUCED INCOME . PPLEMENTAL PAYMENT REL EST

) THAT INCOME HAS **DROPPED** OR **STOPPED.**

EXAMPLE E

AU = 3
MAP = $617

ıe that has dropped or stopped against your cash aid.

ıpleted form is received.

MOM'S GROSS INCOME IN NOVEMBER WAS $606. SHE LOST HER JOB AND HAD NO EARNINGS IN JANUARY. HER JANUARY GRANT IS $11.

MOM'S CA7 REPORTING NOVEMBER'S INCOME WAS LATE. SHE WOULD HAVE BEEN ELIGIBLE FOR THE FOLLOWING DISREGARDS:

$75	WORK EXPENSE DISREGARD
$90	CHILD CARE DISREGARD , AND
$167	$30 and 1/3 DISREGARD
$332	TOTAL

COUNTY USE ONLY

DATE POSTMARKED

CASE NAME AND NUMBER

Supp. Month		JAN.
Est. Earned Income	$	0
W/E Disregard	—	
Dep. Care Disregard	—	
Net Earnings	= $	
Total Aid Before O/P Adj.	+	11
Special Needs	—	
Disregards Not Allowed	+	332
Other Countable Income	+	
Support Disregards	+	
Net Available Income	$	343
80% MAP	$	494
Net Available Income	—	343
Supplemental Payment	$	151

COMMENTS:

☑ APPROVED ☐ DENIED

EW SIGNATURE DATE

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification including contacting the above named person, employer or agency.
- **I further declare under penalty of perjury under the laws of the State of California that the statements I have given on this form are true and correct to the best of my knowledge.**
- I authorize the county to obtain any verification of income and circumstances necessary to process this request. This authorization is valid for 30 days from the date signed.

SIGNATURE — DATE SIGNED

SIGNATURE OF SPOUSE OR OTHER ADULT RECIPIENT — DATE SIGNED

ADDRESS — CITY — PHONE

On this form, disclosure of your Social Security Number (SSN) is voluntary. The SSN will be used to identify you and your records. If we cannot identify you, you may not get any extra money.

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

AFDC — REDUCED INCOME JPPLEMENTAL PAYMENT RE JEST

) THAT INCOME HAS **DROPPED** OR **STOPPED.**

e that has dropped or stopped against your cash aid.

pleted form is received.

EXAMPLE F

AU = 4
MAP = $734

MOM EXPERIENCED A DROP IN INCOME IN JANUARY. HER CA7 REPORTING NOVEMBER'S INCOME WAS LATE, SO THE FOLLOWING DISREGARDS WERE NOT ALLOWED IN NOVEMBER.

$75 WORK EXPENSE DISREGARD, AND
$30 DISREGARD
$105 TOTAL

MOM'S EARNED INCOME IN NOVEMBER WAS $466. HER JANUARY GRANT IS $268.

MOM'S JANUARY INCOME IS $300.

COUNTY USE ONLY

DATE POSTMARKED

CASE NAME AND NUMBER

Supp. Month		JAN.
Est. Earned Income	$	300
W/E Disregard	—	75
Dep. Care Disregard	—	
Net Earnings	= $	225
Total Aid Before O/P Adj.	+	268
Special Needs	—	
Disregards Not Allowed	+	105
Other Countable Income	+	
Support Disregards	+	
Net Available Income	$	598
80% MAP	$	587
Net Available Income	—	598
Supplemental Payment	$	Ø

COMMENTS.

☐ APPROVED ☑ DENIED

EW SIGNATURE DATE

CERTIFICATION

- I understand that the statements I have made on this form are subject to investigation and verification including contacting the above named person, employer or agency.
- **I further declare under penalty of perjury under the laws of the State of California that the statements I have given on this form are true and correct to the best of my knowledge.**
- I authorize the county to obtain any verification of income and circumstances necessary to process this request. This authorization is valid for 30 days from the date signed.

SIGNATURE — DATE SIGNED

SIGNATURE OF SPOUSE OR OTHER ADULT RECIPIENT — DATE SIGNED

ADDRESS — CITY — PHONE

On this form, disclosure of your Social Security Number (SSN) is voluntary. The SSN will be used to identify you and your records. If we cannot identify you, you may not get any extra money.

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

AFDC — REDUCED INCOME JPPLEMENTAL PAYMENT RL JEST

) THAT INCOME HAS DROPPED OR STOPPED.

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EXAMPLE G

AU = 4
MAP = $734

CASE WAS DISCONTINUED ON APRIL 30th.

RECIPIENT REAPPLIES AND AID IS AUTHORIZED ON MAY 16th.

MARCH'S NNI RETROSPECTIVELY BUDGETED TO MAY WAS $300.

IN MAY, THE RECIPIENT HAS NO INCOME.

PRORATED MAY GRANT IS $224.

(COMPUTE THE RISP AS IF IT AND THE REGULAR GRANT WERE FOR THE FULL MONTH. PRORATE THE RISP THE RECIPIENT IS ENTITLED TO AT THE END OF THE COMPUTATION.)

PRORATE RISP------>

COUNTY USE ONLY

DATE POSTMARKED

CASE NAME AND NUMBER

Supp. Month		MAY
Est. Earned Income	$	0
W/E Disregard	—	
Dep. Care Disregard	—	
Net Earnings	= $	
Total Aid Before O/P Adj.	+	434
Special Needs	—	
Disregards Not Allowed	+	
Other Countable Income	+	
Support Disregards	+	
Net Available Income	$	434
80% MAP	$	587
Net Available Income	—	434
Supplemental Payment	$	153 ~~$76~~

COMMENTS: *153 PRORATED MAY 16-31 = 76.

☑ APPROVED ☐ DENIED

EW SIGNATURE DATE

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